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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

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|----------------------------------|---|---------------------------|
| DANIEL JACOBSON, |) | Case No. EDCV 11-342-OP |
| |) | |
| Plaintiff, |) | |
| v. |) | MEMORANDUM OPINION; ORDER |
| |) | |
| MICHAEL J. ASTRUE, |) | |
| Commissioner of Social Security, |) | |
| |) | |
| Defendant. |) | |

The Court¹ now rules as follows with respect to the disputed issues listed in the Joint Stipulation (“JS”).²

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¹ Pursuant to 28 U.S.C. § 636(c), the parties consented to proceed before the United States Magistrate Judge in the current action. (ECF Nos. 7, 8.)

² As the Court advised the parties in its Case Management Order, the decision in this case is made on the basis of the pleadings, the Administrative Record, and the Joint Stipulation filed by the parties. In accordance with Rule 12(c) of the Federal Rules of Civil Procedure, the Court has determined which party is entitled to judgment under the standards set forth in 42 U.S.C. § 405(g).

I.

DISPUTED ISSUES

As reflected in the Joint Stipulation, the disputed issues which Plaintiff raises as the grounds for reversal and/or remand are as follows:

- (1) Whether the Administrative Law Judge (“ALJ”) properly considered the opinion of the treating physician;
- (2) Whether the ALJ properly assessed Plaintiff’s residual functional capacity (“RFC”); and
- (3) Whether the ALJ posed a complete hypothetical to the vocational expert (“VE”).

(JS at 2-3.)

II.

STANDARD OF REVIEW

Under 42 U.S.C. § 405(g), this Court reviews the Commissioner’s decision to determine whether the Commissioner’s findings are supported by substantial evidence and whether the proper legal standards were applied. DeLorme v. Sullivan, 924 F.2d 841, 846 (9th Cir. 1991). Substantial evidence means “more than a mere scintilla” but less than a preponderance. Richardson v. Perales, 402 U.S. 389, 401, 91 S. Ct. 1420, 28 L. Ed. 2d 842 (1971); Desrosiers v. Sec’y of Health & Human Servs., 846 F.2d 573, 575-76 (9th Cir. 1988). Substantial evidence is “such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” Richardson, 402 U.S. at 401 (citation omitted). The Court must review the record as a whole and consider adverse as well as supporting evidence. Green v. Heckler, 803 F.2d 528, 529-30 (9th Cir. 1986). Where evidence is susceptible of more than one rational interpretation, the Commissioner’s decision must be upheld. Gallant v. Heckler, 753 F.2d 1450, 1452 (9th Cir. 1984).

III.

DISCUSSION

A. The ALJ's Findings.

The ALJ found that Plaintiff has the severe impairments of depression, history of alcohol abuse, and history of methamphetamine abuse. (Administrative Record (“AR”) at 9.) The ALJ concluded that Plaintiff has the RFC to perform a full range of work at all exertional levels, with the following limitation: Plaintiff should work with things, rather than people. (*Id.* at 11.)

Relying on the testimony of the VE, the ALJ determined that Plaintiff was able to perform his past relevant work as a diesel mechanic as actually and generally performed. (*Id.* at 17.) In the alternative, the ALJ asked the VE whether other jobs existed in the national economy for an individual with Plaintiff’s age, education, work experience, and RFC. (*Id.* at 18.) Based on the testimony of the VE, the ALJ determined that Plaintiff could perform the requirements of such occupations as auto body repair helper (Dictionary of Occupational Titles (“DOT”) 807.687-010); store labor person (DOT 922.687-058); and airport maintenance person (DOT 899.687-014). (AR at 18.)

B. The ALJ Properly Considered the Opinion of Plaintiff’s Treating Physician.

Plaintiff contends that the ALJ failed to provide “sufficient rationale” for disregarding the August 24, 2009, opinion of Plaintiff’s treating opinion, Dr. Amador, failed to properly consider Dr. Amador’s opinion that Plaintiff was not able to obtain and sustain full-time employment, and failed to provide specific and legitimate reasons supported by substantial evidence for rejecting Dr. Amador’s opinion. (JS at 4.)

Specifically, on August 24, 2009, Dr. Amador completed a “Narrative Report (Adult),” consisting of a series of criteria, with items to be circled if they

1 “apply to the case,” in which he indicated that Plaintiff had been seen by Riverside
 2 County Mental Health since February 6, 2008, and was last seen on June 1, 2009;
 3 Plaintiff’s diagnosis was dysthymia,³ major depression, recurrent, severe with
 4 psychotic features; and alcohol dependence; his prescribed medications were
 5 Citalopram, Quetiapene, Trazodone, Vistaril, and Carmpoal; his thought content
 6 was concrete and ruminative; his psychotic symptoms included both auditory and
 7 visual components, and influence his actions and behavior; his memory was
 8 mildly impaired; his judgment was moderately impaired; there was evidence of
 9 insomnia, depression, anxiety, panic episodes, decreased energy, and isolation;
 10 Plaintiff was not able to maintain a sustained level of concentration, sustain
 11 repetitive tasks for an extended period, or adapt to new or stressful situations; he
 12 was not able to interact appropriately with others such as family, strangers,
 13 co-workers or supervisors/authority; his attitude was anxious; he needs assistance
 14 with medications and keeping appointments; he cannot complete a forty-hour
 15 work week without decompensating; his prognosis was guarded; he has a long
 16 history of depression; frequent relapses on alcohol; auditory and visual
 17 hallucinations; and depressed mood, anhedonia, and difficulty keeping a job. (AR
 18 at 599.)

19 With regard to this report, the ALJ found the following:

20 Little weight [is given to Dr. Amador’s August 24, 2009, report] because
 21 the claimant[’s] MSE [Mental Status Examination] found that the
 22 claimant had concrete thought processes; mildly impaired memory; no
 23 reported suicidal or homicidal ideations; no reported inappropriate
 24

25
 26 ³ Dysthymic disorder consists of a chronically depressed mood that occurs
 27 for most of the day more days than not for at least two years. Diagnostic and
 28 Statistical Manual of Mental Disorders-DSM-IV-TR 376 (Am. Psych. Ass’n ed.,
 4th ed. 2000) (“DSM-IV”).

1 affect; no reported social withdrawal; no reported poor grooming; and
2 the claimant was determined able to manage his own funds.

3 The undersigned . . . finds no support in the findings reported by
4 Dr. Amador. The report primarily summarizes the claimant's subjective
5 complaints and diagnoses but does not present objective clinical or
6 laboratory diagnostic findings that support its conclusions. In addition,
7 the opinion is not supported by the overall record. Accordingly, the
8 undersigned gives little evidentiary weight to this opinion which, if
9 otherwise accepted as credible, would indicate that the claimant could
10 not perform any kind of work.

11 (Id. at 16 (citations omitted).)

12 Plaintiff claims that although the ALJ "seems to acknowledge" all of the
13 "unmarked symptoms" on Dr. Amador's report, he fails to mention the symptoms
14 that Dr. Amador *did* find. (JS at 5.) Plaintiff contends that "it is unfair to the
15 plaintiff for the ALJ to simply dismiss Dr. Amador's extremely relevant opinion
16 by only mentioning insignificant findings while ignoring relevant information and
17 symptoms that do support his findings that plaintiff does not show an ability to
18 maintain a sustained level of concentration, sustain repetitive tasks for an extended
19 period, adapt to new or stressful situations, interact appropriately with others . . .
20 or complete a 40-hour work week without decompensating." (Id.)

21 It is well-established in the Ninth Circuit that a treating physician's opinions
22 are entitled to special weight, because a treating physician is employed to cure and
23 has a greater opportunity to know and observe the patient as an individual.
24 McAllister v. Sullivan, 888 F.2d 599, 602 (9th Cir. 1989). "The treating
25 physician's opinion is not, however, necessarily conclusive as to either a physical
26 condition or the ultimate issue of disability." Magallanes v. Bowen, 881 F.2d 747,
27 751 (9th Cir. 1989). The weight given a treating physician's opinion depends on
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1 whether it is supported by sufficient medical data and is consistent with other
2 evidence in the record. See 20 C.F.R. § 404.1527(d)(2). If the treating
3 physician's opinion is uncontroverted by another doctor, it may be rejected only
4 for "clear and convincing" reasons. Lester v. Chater, 81 F.3d 821, 830 (9th Cir.
5 1995); Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991). If the treating
6 physician's opinion is controverted, it may be rejected only if the ALJ makes
7 findings setting forth specific and legitimate reasons that are based on the
8 substantial evidence of record. Thomas v. Barnhart, 278 F.3d 947, 957 (9th Cir.
9 2002); Magallanes, 881 F.2d at 751; Winans v. Bowen, 853 F.2d 643, 647 (9th
10 Cir. 1987).

11 However, the Ninth Circuit also has held that "[t]he ALJ need not accept the
12 opinion of any physician, including a treating physician, if that opinion is brief,
13 conclusory, and inadequately supported by clinical findings." Thomas, 278 F.3d
14 at 957; see also Matney ex rel. Matney v. Sullivan, 981 F.2d 1016, 1019 (9th Cir.
15 1992). A treating or examining physician's opinion based on the plaintiff's own
16 complaints may be disregarded if the plaintiff's complaints have been properly
17 discounted. Morgan v. Comm'r of Soc. Sec. Admin., 169 F.3d 595, 602 (9th Cir.
18 1999); see also Sandgathe v. Chater, 108 F.3d 978, 980 (9th Cir. 1997); Andrews
19 v. Shalala, 53 F.3d 1035, 1043 (9th Cir. 1995). Additionally, "[w]here the opinion
20 of the claimant's treating physician is contradicted, and the opinion of a
21 nontreating source is based on independent clinical findings that differ from those
22 of the treating physician, the opinion of the nontreating source may itself be
23 substantial evidence; it is then solely the province of the ALJ to resolve the
24 conflict." Andrews, 53 F.3d at 1041; Magallanes, 881 F.2d at 751; Miller v.
25 Heckler, 770 F.2d 845, 849 (9th Cir. 1985).

26 In this case, the ALJ gave little weight to Dr. Amador's report because it
27 was inconsistent with Plaintiff's medical records as a whole and not supported by
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1 objective clinical evidence, internally inconsistent, and unduly reliant on
2 Plaintiff's subjective complaints. (AR at 16.) As discussed below, the Court finds
3 these to be specific and legitimate reasons, supported by substantial evidence.

4 **1. Dr. Amador's Opinion Was Inconsistent with the Record as a**
5 **Whole and Supported by Substantial Evidence.**

6 In his decision, the ALJ set forth a detailed summary of Plaintiff's mental
7 health evidence, noting that "[d]uring the period of adjudication, the claimant's
8 mental status examinations . . . and findings were unremarkable and supported a
9 finding of moderate impairment." (*Id.* at 13.) He then reviewed Plaintiff's various
10 MSEs and reports by treating physicians, including (1) a December 14, 2007, MSE
11 from Riverside Mental Health noting that although Plaintiff was depressed and
12 anxious, he was also alert and oriented to time, place, person, and situation;
13 exhibited calm and cooperative behavior, good eye contact, and good grooming;
14 slow speech; goal directed and logical thought processes; no suicidal or homicidal
15 ideations; no evidence of obsessions, compulsions, delusions, or hallucinations;
16 good impulse control; good insight and judgment; and stable mental health with
17 substance abuse stabilizing (*id.* (citing *id.* at 199-200)); (2) a February 6, 2008,
18 MSE by Dr. Terry Roh, of Riverside Mental Health, revealing that Plaintiff was
19 depressed but oriented to time, place, person, and purpose; had slightly impaired
20 concentration and memory due to alcohol blackouts; had normal speech, motor
21 activity, eye contact, and thought processes; no reported delusions, hallucinations,
22 or evidence of obsessions, compulsions, or phobia; fair impulse control; and fair
23 insight and judgment (*id.* (citing *id.* at 323)); (3) a June 2, 2008, MSE by Dr. Roh,
24 noting that Plaintiff complained of depression, decreased energy, and isolation;
25 had a pleasant attitude; exhibited clearly organized thought; had intact memory
26 and judgment, and could maintain a sustained level of concentration and repetitive
27 tasks for an extended period; could interact appropriately with others, including
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1 family, friends, and co-workers; and could complete a forty-hour work week
2 without decompensating (id. (citing id. at 287)); (4) an August 19, 2008, Riverside
3 Mental Health Report noting that Plaintiff had clearly organized thought
4 processes; intact memory; mildly impaired judgment and pleasant attitude; and a
5 stable prognosis (id. (citing id. at 306)); (5) a February 26, 2009, VA hospital
6 report that Plaintiff was oriented to time, place, and person; had a cooperative
7 attitude and appropriate eye contact; had linear thought processes; no suicidal or
8 homicidal ideations; no hallucinations; fair concentration; and fair insight and
9 judgment (id. (citing id. at 438)); (6) an August 18, 2009, VA hospital report
10 noting that despite complaints of recent suicidal ideations and feelings of
11 hopelessness and helplessness, Plaintiff was fairly groomed; had adequate eye
12 contact; cooperative behavior; congruent affect; linear thought processes; no
13 suicidal or homicidal ideations; no auditory or visual hallucinations; and fair
14 insight and judgment (id. (citing id. at 563)); and (7) an August 20, 2009, MSE
15 reporting identical findings to those reported by the VA on August 18, 2009,
16 although also noting “passive suicidal ideation” (id. (citing id. at 581)).

17 The ALJ gave “great weight” to the opinions in the June 2, 2008, “Narrative
18 Report (Adult),” referenced above, completed by Dr. Roh, another treating
19 psychiatrist at Riverside County Mental Health.⁴ (Id. at 13, 15 (citing id. at 287).)
20 The ALJ found that Dr. Roh’s report was supported by the record and consistent
21 with Plaintiff’s ability to perform unskilled work in a non-public setting. (Id. at
22 15.) Dr. Roh diagnosed Plaintiff with dysthymic disorder. (Id. at 287.) Dr. Roh
23 noted that there was evidence of depression, decreased energy, isolation, apathy,
24 social withdrawal, affective flattening, and an inability to adapt to new or stressful
25 situations. (Id.) He also noted that Plaintiff’s thoughts were clearly organized; he
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27 ⁴ Plaintiff does not allege error with regard to the ALJ’s reliance on Dr.
28 Roh’s opinion.

1 evidenced no delusions, hallucinations, or phobias, his memory and judgment
2 were intact, he had the ability to maintain a sustained level of concentration,
3 sustain repetitive tasks for an extended period, and interact appropriately with
4 family, strangers, and co-workers, but not supervisors or authority; his attitude was
5 pleasant; and he was able to complete a forty-hour work week without
6 decompensating. (Id.) He noted Plaintiff's prognosis as stable. (Id.)

7 The ALJ also gave "some weight" to the opinions of consulting psychiatrist,
8 Edward P. O'Malley, M.D., who prepared a June 23, 2008, Psychiatric Review
9 Technique. (Id. at 15 (citing id. at 288-98).) Dr. O'Malley found that the
10 objective medical evidence supported a finding that Plaintiff's affective disorder
11 was not severe. (Id. at 288.) He also found that Plaintiff had mild limitations in
12 activities of daily living, maintaining social functioning, and maintaining
13 concentration persistence or pace; and had one to two episodes of
14 decompensation. (Id. at 296.) The ALJ found the report only partially supported
15 by the record and consistent with Plaintiff's ability to perform unskilled work in a
16 non-public setting. (Id. at 16.) He also found, however, that the record supported
17 more moderate limitations in social functioning than found by Dr. O'Malley. (Id.)
18 The ALJ properly gave more weight to the evidence that was consistent with the
19 record as a whole.

20 Moreover, the ALJ's determination was well supported by objective clinical
21 findings. Andrews, 53 F.3d at 1041 (it is solely the province of the ALJ to resolve
22 conflicts in medical opinion evidence). In support of his argument, Plaintiff
23 specifically points to two reports containing global assessment of functioning
24 ("GAF") scores: a December 14, 2007, mental health intake reporting a GAF
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1 score of 25 (AR at 207),⁵ and a February 7, 2008, intake reporting a GAF score of
2 50 (id. at 325).⁶

3 As a threshold matter, the Commissioner has no obligation to credit or even
4 consider GAF scores in the disability determination. See 65 Fed. Reg. 50746,
5 50764-65 (Aug. 21, 2000) (“The GAF scale . . . is the scale used in the multiaxial
6 evaluation system endorsed by the American Psychiatric Association. It does not
7 have a direct correlation to the severity requirements in our mental disorders
8 listings.”); see also Howard v. Commissioner of Soc. Sec., 276 F.3d 235, 241 (6th
9 Cir. 2002) (“While a GAF score may be of considerable help to the ALJ in
10 formulating the RFC, it is not essential to the RFC’s accuracy. Thus, the ALJ’s
11 failure to reference the GAF score in the RFC, standing alone, does not make the
12 RFC inaccurate.”). GAF scores include a significant number of non-medical
13 factors, such as homelessness and legal troubles, that do not necessarily translate
14 into work-related functional impairments. DSM-IV 33.

15 In this case, the GAF scores were assessed on days when Plaintiff was
16 hospitalized for substance abuse. In February 2008, when assessed with the GAF
17 of 50, Plaintiff had abused substances in the park, got drunk, and woke up in the
18 treatment facility. (AR at 320.) The intake form reflects that Plaintiff reported his
19 two most recent hospitalizations had been in December 2007 “for drinking too
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21 ⁵ A GAF score between 21 and 30 falls into the category described as
22 follows: “Behavior is considerably influenced by delusions or hallucinations OR
23 serious impairment in communication of judgment (e.g., sometimes incoherent,
24 acts grossly inappropriately, suicidal preoccupation) OR inability to function in
25 almost all areas (e.g., stays in bed all day; no job, home, or friends). DSM-IV 34.

26 ⁶ A GAF score between 41 and 50 falls into the “serious symptoms”
27 category, described as “(suicidal ideation, severe obsessional rituals, frequent
28 shoplifting) OR any serious impairment in social, occupational, or school
functioning (e.g., no friends, unable to keep a job).” DSM-IV 34.

1 much.” (Id. at 326 (internal quotation marks omitted).) He also stated that he did
2 not remember much of November or December 2007. (Id. at 328.)

3 Indeed, it was during the December 2007 hospitalization that Plaintiff was
4 initially assessed at his December 11, 2007, intake, with a GAF score of 25. (Id. at
5 178, 207.) He reported at that time that he had become very depressed, and
6 drowned his depression in alcohol. (Id. at 208.) He also apparently had stated he
7 wanted to kill himself and had cut himself on the left wrist with a knife. (Id. at
8 178.) However, at the time of discharge three days later, on December 14, 2007,
9 the GAF score had improved to 63,⁷ and the discharging doctor reported that
10 Plaintiff was alert, cooperative, oriented, goal-directed and logical, with no
11 evidence of suicidal or homicidal ideation or psychosis, had good judgment and
12 impulse control, and his prognosis was “fair-to-good with the recommended
13 treatment.” (Id. at 179.) Thus, Plaintiff’s reliance on the GAF scores of 25 and
14 50, scores that reflect Plaintiff’s episodes of decompensation due to substance
15 abuse, is misplaced.

16 In fact, the ALJ provided detailed findings on Plaintiff’s ongoing problems
17 with alcohol. (Id. at 9-10, 14-15.) He noted that “[t]he record suggests that the
18 claimant’s alcohol use contributed to the occurrence of auditory or visual
19 hallucinations.” (Id. at 15.) He went on to cite several instances to support this
20 finding.⁸ (Id.) He noted that Plaintiff’s mental health treatment, including regular
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23 ⁷ A GAF score between 61 and 70 and 50 falls into the “Some mild
24 symptoms” category, described as “(e.g., depressed mood and mild insomnia) OR
25 some difficulty in social, occupational, or school functioning . . . but generally
26 functioning pretty well” DSM-IV 34.

27 ⁸ He referenced (1) a July 18, 2007, report from Riverside Mental Health
28 that Plaintiff had been found in a ditch with an empty bottle of alcohol; (2) a

(continued...)

1 participation in a 12-step program, was effective in stabilizing his mental
2 condition. (Id. at 14.)

3 Plaintiff also relies on an August 20, 2008, Narrative Report completed by
4 Dr. Amador. Although Dr. Amador again indicated Plaintiff could not maintain a
5 sustained level of concentration, sustain repetitive tasks for an extended period,
6 adapt to new or stressful situations, interact appropriately with others except
7 family, and could not complete a forty-hour work week without decompensating,
8 that report also indicates that Petitioner exhibits clearly organized thoughts, intact
9 memory, intact judgment, pleasant attitude, and a stable prognosis. (Id. at 360.)
10 Dr. Amador also noted that “[d]epression seems to be under control [and the]
11 [o]nly thing bothering [Plaintiff] is insomnia at this time.” (Id.) The ALJ
12 specifically rejected this assessment as internally inconsistent with the mental
13 status findings. (Id. at 16 (citing id. Ex. 9F/3).⁹) Plaintiff did not otherwise
14 contest the ALJ’s finding regarding this report.

15 Similarly, although Plaintiff also relies on an August 19, 2008, Narrative
16 Report signed by an unnamed clinician, that report while indicating Plaintiff was
17 unable to complete a forty-hour work week without decompensating, also
18 indicated his thoughts were clearly organized, no evidence of hallucinations,
19 delusions, or paranoid thoughts, intact memory, mildly impaired judgment,
20 depression, anxiety, and an inability to manage his own funds due to his substance
21

22
23 ⁸(...continued)

24 February 2, 2008, alcohol blackout; and (3) the February 26, 2009, VA report that
25 Plaintiff was drinking between one pint to 1/5 of whiskey per day and reported
26 depression, anxiety, hopelessness, and auditory or visual hallucinations, as well as
27 that he was taking medications and “boozing at the same time.” (AR at 15
(citations omitted).)

28 ⁹ Exhibit 9F/3 corresponds with page 360 of the AR.

1 abuse history. (Id. at 306.) The report also indicated Plaintiff's prognosis was
2 stable. (Id.) The ALJ noted this report in his decision in discussing mental status
3 examinations that "were consistently unremarkable," and with indication that
4 Plaintiff's "mental status was stable." (Id. at 13 (citing id. Ex. 8F/3).¹⁰) Plaintiff
5 did not otherwise contest the ALJ's finding regarding this report.

6 The ALJ also properly rejected Dr. Amador's opinion as unduly reliant on
7 Plaintiff's subjective complaints.¹¹ Tommasetti v. Astrue, 533 F.3d 1035, 1041
8 (9th Cir. 2008) ("An ALJ may reject a treating physician's opinion if it is based 'to
9 a large extent' on a claimant's self-reports that have been properly discounted as
10 incredible."); Batson v. Comm'r, 359 F.3d 1190, 1195 (9th Cir. 2004) (holding
11 that an ALJ properly discounted two treating doctors' opinions because they were
12 in the form of a checklist, did not have supportive objective evidence, were
13 contradicted by other statements and assessments of the claimant's medical
14 condition and were based on the claimant's subjective descriptions of pain). The
15 ALJ properly discounted Plaintiff's credibility, and Plaintiff does not submit any
16 contentions asserting error with this finding.

17 The ALJ also properly found that Dr. Amador's August 24, 2009, MSE was
18 internally inconsistent with his conclusion. Specifically, Dr. Amador's conclusion
19 that Petitioner was unable to complete a normal work week, sustain concentration
20 or repetitive tasks, or interact appropriately with others is internally inconsistent
21 with his findings that Plaintiff's thought processes were concrete, he had only
22 mildly impaired memory, there was no report of inappropriate affect, no suicidal
23 or homicidal ideations, no social withdrawal, and only moderately impaired
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25 ¹⁰ Exhibit 8F/3 corresponds with page 306 of the AR. Although unclear as
26 to whether this opinion is from an acceptable medical source, the ALJ discussed it
27 as if it was.

28 ¹¹ Plaintiff does not contend that the ALJ's credibility finding was error.

1 judgment. (AR at 599.) Johnson v. Shalala, 60 F.3d 1428, 1433 (9th Cir. 1995)
2 (explaining that internal contradiction is a specific, legitimate reason for rejecting
3 a treating physician's opinion).

4 Based on the foregoing, the Court finds that the ALJ provided specific and
5 legitimate reasons supported by substantial evidence of record to discount Dr.
6 Amador's opinions. Thus, there was no error.

7 **C. The ALJ Properly Considered Plaintiff's RFC.**

8
9 Plaintiff contends that it was error for the ALJ not to include Dr. Amador's
10 2009 limitations in the ALJ's RFC, because the limitations set forth in Dr.
11 Amador's report "have significant vocational ramifications because the functional
12 impairments affect the plaintiff's ability to perform and sustain full-time work in
13 any work-related environment." (JS at 24.) Specifically, Plaintiff claims that the
14 reported inability to maintain a sustained level of concentration, sustain repetitive
15 tasks for an extended period, adapt to new or stressful situations, or complete a
16 forty-hour work week without decompensating, would "clearly impact his working
17 capabilities and the jobs he is able to competently perform." (Id.)

18 In determining a claimant's disability status, an ALJ has a responsibility to
19 determine the claimant's RFC after considering "all of the relevant medical and
20 other evidence" in the record, including all medical opinion evidence. 20 C.F.R.
21 §§ 404.1545(a)(3), 404.1546(c), 416.945(a)(3), 416.946(c); see also Soc. Sec.
22 Ruling 96-8p. As previously discussed, the ALJ properly relied on the numerous
23 MSEs by Plaintiff's treating physicians, and gave appropriate weight to the
24 Narrative Report of Dr. Roh, all of which constituted substantial evidence in
25 support of the ALJ's RFC finding.

26 Even if it was error not to include Dr. Amador's findings, the Court agrees
27 with Defendant that any error was harmless, as additional findings at Step Four
28

1 and Five would be needed if Plaintiff had been found disabled. That is, the ALJ
2 would then have to determine whether Plaintiff's alcohol and drug use were a
3 contributing factor in a finding of "disabled."¹²

4 Given the extensive evidence in the record, including in Dr. Amador's
5 report, that Plaintiff's drinking and drug abuse were ongoing throughout the
6 adjudicatory period, that Plaintiff's failure to regularly and fully participate in
7 group therapy sessions or his 12-step program were detrimental to his progress,
8 that is disorders were induced by alcohol use (see, e.g., AR at 306, 437), and that
9 alcohol contributed to Plaintiff's blackouts, hallucinations, and other issues (id. at
10 15, 306, 323, 326), it is more than likely that Plaintiff would not be able to meet
11 his burden of showing objective medical evidence proving that he has disabling
12 impairments notwithstanding his alcohol and drug use. 42 U.S.C. § 405(g).

13 Accordingly, the Court finds that the ALJ's RFC determination was
14 consistent with the other evidence of record relied on by the ALJ, particularly the
15 various MSE reports, and the Narrative Report of Dr. Roh. Thus, the Court finds
16 that there was no error and, even if there was error, it was harmless.

17
18 **D. The ALJ Posed a Complete Hypothetical to the VE.**

19 Plaintiff contends that the hypotheticals posed to the VE did not incorporate
20 Dr. Amador's findings regarding Plaintiff's inability to maintain a sustained level
21 of concentration, sustain repetitive tasks for an extended period, or complete a
22

23 ¹² If an ALJ determines that the claimant is disabled, and there is evidence
24 of substance abuse, the ALJ must then determine whether the substance abuse is a
25 contributing factor material to the disability, i.e., whether the claimant would still
26 be disabled if she stopped abusing drugs or alcohol. 20 C.F.R. §§ 404.1535,
27 416.935 ("If we find that you are disabled and have medical evidence of your drug
28 addiction or alcoholism, we must determine whether your drug addiction or
alcoholism is a contributing factor material to the determination of disability"); see
also Bustamente v. Massanari, 262 F.3d 949, 954-55 (9th Cir. 2001).

1 forty-hour work week without decompensating. (JS at 16-17.)

2 “In order for the testimony of a VE to be considered reliable, the
3 hypothetical posed must include ‘all of the claimant’s functional limitations, both
4 physical and mental’ supported by the record.” Thomas, 278 F.3d at 956 (quoting
5 Flores v. Shalala, 49 F.3d 562, 570-71 (9th Cir. 1995)). Hypothetical questions
6 posed to a VE need not include all alleged limitations, but rather only those
7 limitations which the ALJ finds to exist. See, e.g., Magallanes, 881 F.2d at
8 756-57; Copeland v. Bowen, 861 F.2d 536, 540 (9th Cir. 1988); Martinez v.
9 Heckler, 807 F.2d 771, 773-74 (9th Cir. 1986). As a result, an ALJ must propose
10 a hypothetical that is based on medical assumptions, supported by substantial
11 evidence in the record, that reflects the claimant’s limitations. Osenbrock v.
12 Apfel, 240 F.3d 1157, 1163-64 (9th Cir. 2001) (citing Roberts v. Shalala, 66 F.3d
13 179, 184 (9th Cir. 1995)); see also Andrews, 53 F.3d at 1043 (although the
14 hypothetical may be based on evidence which is disputed, the assumptions in the
15 hypothetical must be supported by the record).

16 In his hypothetical to the VE, the ALJ asked if a hypothetical person who
17 did not have exertional limitations, but who would be limited to working primarily
18 with things, rather than with people, could perform Plaintiff’s past relevant work.
19 (AR at 61.) The VE found that such an individual could perform that work and
20 alternatively identified several other occupations that would be available. (Id. at
21 62.)

22 As the Court concluded above, the record evidence did not support the more
23 extreme limitations and conclusion of Dr. Amador, and that opinion was properly
24 discounted by the ALJ. Accordingly, the ALJ was not obligated to include those
25 limitations in his hypothetical to the VE. Rollins v. Massanari, 261 F.3d 853, 857
26 (9th Cir. 2001) (“Because the ALJ included all of the limitations that he found to
27 exist, and because his findings were supported by substantial evidence, the ALJ
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1 did not err in omitting the other limitations that Rollins had claimed, but had failed
2 to prove.”).

3 The ALJ gave great weight to Dr. Roh’s opinions that Plaintiff was able to
4 maintain a sustained level of concentration, sustain repetitive tasks for an extended
5 period, and interact appropriately with others, including family, friends, and co-
6 workers. (AR at 15.) In fact, the ALJ’s limitation to working with things, rather
7 than people, gives Plaintiff every benefit of the doubt and is arguably more
8 restrictive than Dr. Roh’s opinion would warrant.

9 Because the ALJ properly discounted Dr. Amador’s opinion, and gave great
10 weight to Dr. Roh’s opinions, and because the ALJ’s RFC and hypothetical to the
11 VE was supported by the evidence of record, the ALJ appropriately relied on the
12 VE’s testimony. Bayliss v. Barnhart, 427 F.3d 1211, 1217-18 (9th Cir. 2005). In
13 short, the Court finds that the ALJ presented a complete hypothetical question to
14 the VE. Thus, there was no error.

15
16 **IV.**

17 **ORDER**

18 Based on the foregoing, IT THEREFORE IS ORDERED that Judgment be
19 entered affirming the decision of the Commissioner, and dismissing this action
20 with prejudice.

21
22 Dated: September 20, 2011



23 HONORABLE OSWALD PARADA
24 United States Magistrate Judge
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